

Please print or type in black ink only. See instructions on reverse *before* completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER

| | | |
|--------------|-----------------|--|
| Company name | | Hire date (mm/dd/yyyy) |
| Group number | Enrollment unit | Effective enrollment or coverage date (mm/dd/yyyy) |

NEW ENROLLMENT Check one:

| | |
|---|---|
| <input type="checkbox"/> New hire (complete sections A, B, C, D) | <input type="checkbox"/> Other coverage loss (complete sections A, B, C, D) |
| <input type="checkbox"/> Open enrollment (complete sections A, B, C, D) | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> New group | Event date (mm/dd/yyyy) _____ |
| PLAN Check one: <input type="checkbox"/> HMO <input type="checkbox"/> Deductible Plan <input type="checkbox"/> Other _____ | |

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

| | |
|--|--|
| <input type="checkbox"/> Add dependents (complete sections A, B, D) | <input type="checkbox"/> Delete dependents (complete sections A, B, D) |
| *Reason: (see Change Table) _____ Event date (mm/dd/yyyy) _____ | |
| <input type="checkbox"/> Name change (complete sections A, B, D) From: _____ To: _____ | |
| <input type="checkbox"/> Address change (complete section A) | <input type="checkbox"/> Telephone change (complete section A) |

A. EMPLOYEE

| | | | |
|--------------------------------------|------------|-------------------------|--|
| Medical record no. (if known) | | Social Security no. | |
| Name (Last, First, MI) | | Birth date (mm/dd/yyyy) | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Home address | Apt. no. | City | State ZIP |
| Work phone | Home phone | E-mail | |
| Preferred spoken or written language | | Ethnicity | |

B. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI) Ê

| | | | |
|--|---|--|---------------------------|
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Social Security no. Ê |
| Spouse/Domestic partner name: | | | Birth date (mm/dd/yyyy) Ê |
| Former last name (if any): | | | Medical record no. Ê |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | <input type="checkbox"/> Child <input type="checkbox"/> Student | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Social Security no. Ê |
| Dependent name: | | | Birth date (mm/dd/yyyy) Ê |
| Relationship: | | | Medical record no. Ê |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | <input type="checkbox"/> Child <input type="checkbox"/> Student | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Social Security no. Ê |
| Dependent name: | | | Birth date (mm/dd/yyyy) Ê |
| Relationship: | | | Medical record no. Ê |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | <input type="checkbox"/> Child <input type="checkbox"/> Student | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Social Security no. Ê |
| Dependent name: | | | Birth date (mm/dd/yyyy) Ê |
| Relationship: | | | Medical record no. Ê |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | <input type="checkbox"/> Child <input type="checkbox"/> Student | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Social Security no. Ê |
| Dependent name: | | | Birth date (mm/dd/yyyy) Ê |
| Relationship: | | | Medical record no. Ê |

Do any of dependents above live at another address? Yes No If yes, complete the following:

| | |
|-------------------------------|----------------|
| Name (Last, First, MI): _____ | Address: _____ |
|-------------------------------|----------------|

C. OTHER COVERAGE Including yourself, do any of the persons listed above have other coverage? Yes No

| | | | |
|------|------------------------|---------------------------|-----------|
| Name | Insurance carrier name | Policy no./Effective date | Phone no. |
|------|------------------------|---------------------------|-----------|

D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

| | | | |
|------------------------------|------|--------------------|------|
| Employee/Applicant signature | Date | Employer signature | Date |
|------------------------------|------|--------------------|------|

*Additional documentation may be required.

General Instructions:

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A through C. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscribers should retain the last copy for their records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates, as they affect the Health Plan dues.

If making a change, the subscriber must always complete this section, even when making minor changes to the account so our information is current. Please mark the box if your address is new.

Section A: The subscriber must complete this section.

Section B: The subscribers must indicate the requested change they are making to their account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification Form* may be required.

Sections C, D: The subscriber must complete these sections.

Change Table

Add dependent

Acquired student status*

Family adoption*

Loss of coverage

New spouse (marriage)*

Moved into service area

Newborn addition

Open enrollment

Event date

Student status date

Adoption date

Coverage loss date

Marriage date

Move date

Birth date

Open enrollment effective date

Delete dependent

Loss of student status

Divorce

Member deceased*

Delete dependent(s)

Open enrollment

Event date

Status change date

Divorce date

Death date

Dependent termination date

Open enrollment effective date

*Additional documentation may be required.